

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">DATE</th> <th style="width: 15%; text-align: center;">INITIAL</th> </tr> </thead> <tbody> <tr> <td>1. Check logged (Front desk)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>2. Check rec'd (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>3. Check correct (Superv.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>4. Check logged (Clerical/Cert.)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		DATE	INITIAL	1. Check logged (Front desk)	_____	_____	2. Check rec'd (Clerical/Cert.)	_____	_____	3. Check correct (Superv.)	_____	_____	4. Check logged (Clerical/Cert.)	_____	_____
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SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
<p>1. Check statute reference as applicable to CON application (see statute for detail):</p> <p>_____ 19a-638. Additional function or service, Change of Ownership, Service Termination. No Fee Required.</p> <p>_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding \$400,000 but less than or equal to \$1,000,000. Fee Required.</p> <p>_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding \$1,000,000 or other capital expenditure exceeding \$1,000,000. Fee Required.</p> <p>_____ 19a-638 and 19a-639. Fee Required.</p> <p>2. Enter \$0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.</p> <p>3. Enter \$400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding \$400,000 but less than or equal to \$1,000,000</p> <p>4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding \$1,000,000 or other capital expenditure exceeding \$1,000,000 is checked above OR if both 19a-638 and 19a-639 are checked):</p> <p style="margin-left: 20px;">a. Base fee: _____</p> <p style="margin-left: 20px;">b. Additional Fee: (Capital Expenditure Assessment) _____</p> <p style="margin-left: 20px;">(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) (\$ _____ x .0005)</p> <p style="margin-left: 20px;">c. Sum of base fee plus additional fee: (Lines A3a + A3b) _____</p> <p style="margin-left: 20px;">d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).</p>	<p style="text-align: right;">\$ 1,000.00</p> <p style="text-align: right;">\$ _____ .00</p> <p style="text-align: right;">\$ _____ .00</p>
SECTION B TOTAL FEE DUE: _____	\$ _____ .00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)